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Editorial. Author copy.

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Some of you may think that the words 'euthanasia' and 'critical care' should not be used in the same sentence. Some of you may go even further and think that those words should certainly not be written about in an Editorial and discussed in relation to critical care nursing practice. You see, there are certain words that will raise immediate and strong responses: death, dying and euthanasia being amongst these. And this Editorial will undoubtedly provoke reaction in some critical care nurses.

This Editorial is not written to promote a particular view on the issue of euthanasia, nor offer persuasive arguments supporting either the 'for' or 'against' factions. The purpose of this piece is to make the case for careful and critical reflection on how we understand, practice and articulate end-of-life nursing care in light of on-going discussions about euthanasia, and thoughtfully consider how patients and their families may understand that care.

If we look at the debate gathering momentum across the world, we see increasing interest about euthanasia and its place, or not, in modern health care. Any reading about euthanasia reveals well-used concepts such as: self-determinism and human dignity; active and passive euthanasia; and acts of omission or action. These can be complex issues to fully comprehend with the general public holding many different viewpoints about death and dying in the context of health care (Cox et al., 2013). For example, there are areas of disagreement with many people unable to differentiate between commonly undertaken end-of-life practices e.g. discontinuing medical treatment and acts of euthanasia (Marcoux et al., 2007). The general public may not be alone in this confusion. Results from one recent study identified that over half of the critical care doctors and nurses surveyed were unable to agree on definitions of euthanasia and treatment withdrawal (Kranidiotis et al., 2015).

It has always struck me as slightly odd that present-day debates about euthanasia are so emotionally charged given that the word 'euthanasia' is originally derived from ancient Greek meaning good (eu) death (thanatos). However, euthanasia is now more synonymous with debates about administration of drugs with the explicit intention of ending a patient's life, at their request. And it is in such debates that other aspects of end-of-life care, especially those relevant to critical care, come under scrutiny by clinicians, academics and ethicists alike.

Such areas often include arguments about whether administering increasingly high dosages of analgesia with the intent of relieving severe pain is, or is not, an act of euthanasia. Debates here are frequently informed by the doctrine of double effect, and whether the intent of analgesic administration (the relief of suffering) is more important than the outcome (the potential shortening of a life). A further issue is whether withdrawal of life-supporting treatments and allowing a natural death to occur, constitutes passive euthanasia. Debates here draw on whether there are differences of allowing an underlying and 'terminal' disease to take its course, as opposed to the intent of extinguishing the life of another individual. This leads to consideration as to whether the term 'passive euthanasia' confuses rather than clarifies understanding of end-of-life practices.

Why it is so important for bedside nurses to be aware of these debates? Many of us will have cared for families who, unable to bear the emotional distress of watching their family member at end of life, ask us if we can stop the pain (theirs or the patient) and 'help the person on their way'. What have been our responses to such requests? And what have we said? Or thinking about how we have described the process of withdrawal of life-sustaining treatments to the family of a patient who has shown no response to escalated medical interventions. How have we replied if a family member has said that the weaning or removal of ventilation and inotropes will only shorten the patient's life and hasten their death? What words do we use? In being aware of the on-going debates about end of life, we can have an understanding about what other perspectives may be held, and be sensitive to those views. End-of-life care can be challenging: families may be distressed and vulnerable, and every patient and family presents the critical care nurse with a unique situation. Given this, it is useful that there are clinical guidance documents (Australian and New Zealand Intensive Care Society 2014, National Institute for Health and Care Excellence 2015, Radbruch et al., 2015) to stimulate our critical thinking, and be used to guide end-of-life care.

What can be taken from this Editorial? When we talk about concepts and care at end of life, it is important to be clear to ourselves and to others, what we mean, what we say, and what our motivations are behind the care given. When we talk to patients/families and to our colleagues, there can be no place for ambiguity or euphemisms. Words must be selected carefully and precisely. Language used at end of life can be emotionally charged with potential for misunderstanding. For example, think about what is said when talking with families about managing pain and distress at end of life. Talking about how 'pain and sedative drugs will be given until pain and distress is relieved, even though this could ultimately shorten life' or saying that 'everything will be given to relieve pain and distress' may appear to be the same. But which is more transparent about the processes of care, the potential impact of that care, and of the underlying intentions behind that care?

It has always been important how we have used words when talking with patients and families in critical care. However, with increasing public and professional debate about choice and care at end of life, the use of words is now even more important. Words are powerful and can influence on many levels, words can affect how we feel and how we think. We need to be care-full of the words we use, and be clear about what they mean to patients and families, to our colleagues, and to how they speak to our values and ethics as critical care nurses.

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